U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 25 August 2005

CASE NOS.: 2004-BLA-121
2004-BLA-6356

In the Matter of:

LINDA C. TOLLIVER, on behalf of
RUFUS W. TOLLIVER (Deceased) and

LINDA C. TOLLIVER, Widow of
RUFUS W. TOLLIVER
Claimant

v.

MAPLE MEADOW MINING COMPANY
Employer

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS
Party-in-Interest

Appearances:

James M. Phemister, Esquire
Lindsay Mahon, Student Caseworker
For the Claimant

Kathy Snyder, Esquire
For the Employer

Before: Gerald M. Tierney
Administrative Law Judge

DECISION AND ORDER – AWARDING BENEFITS ON BOTH CLAIMS

This matter involves two claims for Black Lung Benefits.[1] It involves a now deceased miner's original claim for Black Lung Benefits and a survivor's claim for Black Lung Benefits.

Rufus Tolliver worked at least 34 years as a coal miner (TR 46). Mr. Tolliver, who will be referred to as the miner, filed a claim for Black Lung Benefits on June 1, 2000 (DX 1). The claim was initially denied by the District Director (DX 18) and the miner subsequently appealed the decision (DX 19). On February 21, 2001, the District Director held an informal conference and on March 27, 2001 the District Director issued an award of benefits (DX 38). Employer disagreed and requested a formal hearing before an Administrative Law Judge.

On April 26, 2003, the miner died during the dependency of his claim and never had an opportunity to testify at a hearing (DX 47).

On May 8, 2003, Linda C. Tolliver, who will be referred to as Claimant, filed an application for survivor's benefits (DX 52). The living miner's and survivor's claims were consolidated on January 28, 2004 and remanded to the District Director (DX 50). The District Director denied the survivor's claim on March 9, 2004 finding insufficient evidence that pneumoconiosis hastened the miner's death (DX 73). Claimant disagreed and requested a formal hearing before an Administrative Law Judge (DX 74).

A formal hearing was conducted in Beckley, West Virginia on February 8, 2005.[2] At the hearing, Claimant testified that she was married to the miner on July 5, 1963 and has not remarried since his death (TR 49). Claimant added that she and the miner had adopted their grandson, Justin who is now 16 years old (TR 49).[3] She stated that the miner started having breathing problems (wheezing, coughing, and shortness of breath) in the mid-1980s (TR 50). The miner had to give up yard work, gardening, and coaching Little League (TR 50).

Since the survivor's claim was filed after the implementation of the new regulations limiting the submission of evidence, there will be three categories of medical evidence in this case: (1) evidence admissible in both the living miner's and survivor's claims, (2) evidence

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[1] The Black Lung Act, as amended, is codified at 30 USC §901 with its implementing regulations found at Title 20 of the Code of Federal Regulations. The following abbreviations have been used in this opinion: DX= Director's exhibit, EXLM = Employer's exhibit in the living miner's claim, EXLW= Employer's exhibit in the survivor's claim, CXLM = Claimant's exhibit in the living miner's claim, CXLW = Claimant's exhibit in the survivor's claim, TR = Transcript of the hearing, BCR = Board-certified radiologist, BCI = Board-certified internist, and B = B reader.

[2] At the hearing, Director's exhibits 1 through 81, with the exception of one page referring to a Mr. John Brown, were admitted into evidence. TR 6. All of Claimant's exhibits, 1 through 28, (TR 14-15) were admitted as evidence in the living miner's claim. Whereas only Claimant's exhibits 5, 12, 18, 19, 22, 23, 24, 25, 26, 27, and 28 (TR 19) were admitted into evidence in the survivor's claim. Employer's exhibits (living miner's claim) 1 through 54 and Employer's exhibits (survivor's claim) 1 through 18, 20 through 25, 27, 30, and 32 were identified and marked at the hearing and are hereby admitted into evidence. The record was left open for Employer rebuttal evidence. Post-hearing two motions were filed. On June 7, 2005 an Order was issued admitting the February 28, 2005 deposition of Dr. Perper (EXLW 29) and on June 27, 2005 an Order was issued admitting the January 25, 2005 deposition of Dr. Zaldivar (EXLW 26). Post-hearing, Employer submitted EXLM 55 through 61 and EXLW 33 through 38. Said supplemental reports are hereby admitted into evidence. On July 12, 2005, Employer submitted its closing brief and on July 13, 2005, Claimant filed her closing brief.

[3] Employer stipulated that in the event of an award the miner had two dependents (his wife, Linda and adopted son, Justin) in the living miner's claim and that Claimant had one dependent (Justin) in the survivor's claim (TR 47-48).

admissible only in the living miner's claim, and (3) evidence admissible only in the survivor's claim for benefits.[4]

The following is a summary of the relevant medical evidence in this claim.[5]

Evidence Admissible in Both the Living Miner and Survivor's Claims

Pulmonary Function Studies[6]

Exhibit	Date	Age	Height	FEV 1	MVV	FVC	Qualify
DX 45	10-7-97	61	66"	2.09 *2.37	---- ----	3.18 *4.37	No No
DX 45	6-8-98	62	67"	2.29	----	3.64	No
DX 31	7-26-99	-----	----	2.09 *2.37	---- ----	3.18 *4.37	No No
DX 12	7-17-00	64	66"	2.30	65	4.01	No
DX 33	1-17-01	65	67.5"	1.93 *2.49	54 ----	3.21 *4.09	No No
DX 45	4-30-02	66	66"	2.22 *2.21	---- ----	3.53 *3.74	No No

*post-bronchodilator

Arterial Blood Gas Studies

Exhibit	Date	PO2	PCO2	Qualify
DX 14	7-17-00	96	34	No
DX 45	12-18-00	100 *110	28 *27	No No
DX 33[7]	1-17-01	60	34	Yes

*post-exercise

Medical Reports

Dr. Gaziano examined the miner on July 17, 2000 and noted that the miner had a smoking history of 30 years and that he continued to smoke 8 cigarettes per day (DX 13). He reviewed the miner's occupational history noting that the miner last worked as an electrician and maintenance man. After an unremarkable physical examination, Dr. Gaziano reviewed a chest x-ray that was positive for pneumoconiosis, a vent study that showed a moderate impairment, and arterial blood gases that were normal at rest. He concluded that the miner had coal worker's

[4] As it turns out, all of the exhibits admitted into the survivor's claim were also admitted in the living miner's claim, therefore there is no separate category of evidence submitted only in the survivor's claim.
[5] None of the chest x-rays and CT scans will be listed since the parties stipulated to the existence of pneumoconiosis (TR 6).
[6] Due to the discrepancy in height, qualification of the vent studies is based on an average height of 66.5 inches.
[7] This study was validated by Dr. Gaziano on 2-27-01.

pneumoconiosis and pulmonary hypertension. He attributed these conditions to coal mining and cigarette smoking. He added that the miner had a moderately severe impairment and that he was disabled from mining. Dr. Gaziano stated that pneumoconiosis caused a moderate impairment and the pulmonary hypertension was causing a moderately severe impairment.

Dr. Zaldivar issued a medical note on January 15, 2001 (DX 31) indicating that based on recent chest x-rays, the miner had pneumoconiosis. He noted that the miner's shortness of breath was due to a mild airway obstruction that was partly reversible. For this reason, Dr. Zaldivar prescribed bronchodilator medication for the miner.

Dr. McMillen issued a medical note on January 25, 2001 (DX 32) indicating that he had been following the miner for a number of years for treatment of various medical problems including pneumoconiosis, emphysema, pulmonary hypertension, benign prostatic hypertrophy, colonic polyps, and stomach bexoar. He added that the miner had significant dyspnea on exertion presumably related to emphysema, pneumoconiosis, and possibly pulmonary hypertension.

The report of Dr. Crisalli is dated February 12, 2001 (DX 33). Dr. Crisalli is Board-Certified in Internal Medicine and Pulmonary Disease. Dr. Crisalli examined the miner on January 17, 2001. He reviewed the miner's occupational history of 36 years of underground coal mine employment ending in 1997 and that the miner had a smoking history of ½ packs of cigarettes per day for more than 40 years and continuing. A chest x-ray was positive for pneumoconiosis, vent studies showed a mild obstructive disease which completely reversed after bronchodilators, and a resting arterial blood gas that showed mild arterial hypoxemia. Dr. Crisalli also reviewed additional medical records and concluded, based in part on CT scan evidence, that the miner did not have coal worker's pneumoconiosis but had chronic bronchitis based on chronic productive cough. He added that the mild impairment seen on vent studies was due to chronic bronchitis secondary to the miner's heavy smoking history. He could not explain the existence of bibasilar rales, clubbing of the fingers, and the history of pulmonary hypertension but to say that these were not secondary to coal dust exposure or chronic bronchitis. Dr. Crisalli acknowledged that the miner had a mild pulmonary function impairment but that it was only mild in degree and was nearly completely reversible after bronchodilators. He concluded that said impairment was not sufficient to prevent the miner from performing his last coal mine employment. Dr. Crisalli stated that even if the miner were found to have pneumoconiosis his opinion regarding impairment would not change.

The medical report of Dr. Rosenberg, who is Board-Certified in Internal Medicine and Pulmonary Disease, is dated August 14, 2001 (EXLM 2; DX 46; EXLM 44). He reviewed the medical records and concluded that the x-rays and CT scans were negative for pneumoconiosis. He noted that the miner had a mild degree of COPD based on pulmonary function studies but that it was related to the miner's long and continued cigarette smoking. Dr. Rosenberg concluded that the miner was not totally disabled and was able to perform his last mine employment. He noted that the miner's condition had not change since 1992 and that his conclusions would not change even if the miner were found to have CWP.

The medical report of Dr. Steven Koenig is dated July 20, 2002 (CX 19; DX 45). Dr. Koenig, who is Board-Certified in Internal Medicine, Pulmonary Disease, and Critical Care Medicine, conducted a medical record review and stated that the miner had a pulmonary impairment secondary to obstructive lung disease and was totally disabled from his respiratory disease. He noted that the miner, as an electrician, had to lift 75 to 80 pounds and carry a tool belt weighing 80 pounds. He concluded that according to the objective tests the miner did not have the require VO2 max (working capacity) to perform his last coal mine job. He added that COPD which includes chronic bronchitis and emphysema was the cause of the obstructive disease. He noted that cigarette smoking may have contributed to the COPD and subsequent impairment and disability. However, Dr. Koenig concluded that the coal dust exposure alone significantly contributed to the miner's COPD and subsequent impairment. He added that to claim that the miner's respiratory disability was only due to smoking and had nothing to do with coal dust exposure would be disregarding medical literature on this topic.

Lung Biopsies

On May 8, 2002, Dr. Zaldivar, who is Board-Certified in Internal Medicine, Pulmonary Disease, and Critical Care Medicine, performed a bronchial washing of a right lung mass (DX 45). No malignant cells were found. On August 16, 2002, at the Charleston Area Medical Center, the miner had a bronchoscopy to evaluate a mass in the right lung. The results were negative for carcinoma. On September 4, 2002 the miner had a lymph node biopsy which came back as positive for poorly differentiated non-small cell carcinoma (DX 59). Of significance, the subcarinal lymph node showed fibrosis, sinus histiocytosis, calcifications, and anthracotic pigmentation.

Miscellaneous Medical Records

The record contains the medical records from Princeton Community Hospital (DX 60). The miner was treated for his lung cancer at said hospital from September of 2002 until his death on April 26, 2003. It appears that Dr. Khokar was the miner's attending physician while at Princeton Hospital. In the final discharge report, authored by Dr. Khokar, it was noted that the principle diagnosis was non small cell carcinoma of the lung with synchronous brain and hepatic metastatic disease. Secondary diagnoses included pancreatitis secondary to metastatic disease, chronic obstructive pulmonary disease with pneumoconiosis, and tumor associated pain.

The record contains the medical records from Raleigh General Hospital (DX 62; EXLM 21). According to these records the miner underwent cardiac catheterization in 1997, treatment for gastric bezoar in 1998, treatment for dysphagia and abdominal pain in 2000, and a PET scan in 2002.

The record contains the medical records from Dr. George Zaldivar (DX 59; CX 18; CX 23; DX 45). Dr. Zaldivar treated the miner from October 7, 1997 through August 2002 for his pulmonary condition.

The record contains the medical notes of Dr. Mohammed Khokar (DX 61). Dr. Khokar began treating the miner on 9-19-02 for his lung cancer. He noted a smoking history of 1 ½

packs per day for 50 years. He added that the miner had black lung and pulmonary hypertension. He saw the miner about every two weeks ending on 4-21-03.

The record contains the medical records from Dr. Maria R. Baustani (DX 58). She began treating the miner on 11-27-02 for his breathing. She noted a smoking history of 1 to 1 ½ packs per day quitting in 1994. Dr. Baustani last saw the miner on 1-9-03 noting that the miner had pneumoconiosis and COPD.

The medical notes of Dr. J. Wayne McMillen, who is Board-Certified in Emergency Medicine (CX 12; EXLW 18), indicate that he started seeing the miner in December of 1987 for pain in his legs. He noted a smoking history of one pack per for 40 years. He concluded that the miner may have peripheral neuropathy versus lumbar disc. Dr. McMillen treated the miner on a regular basis for various ailments over the years including low back pain, hemorrhoids, and chest pain. In 1996, a one centimeter pulmonary nodule in the right lung was identified. By 1997, Dr. McMillen had noted a diagnosis of pneumoconiosis, emphysema, and pulmonary hypertension. Dr. McMillen last treated the miner on April 21, 2002.

The treatment records of Dr. Kourosh Ghalili (CX 22; DX 45) indicate that Dr. Ghalili saw the miner on 8-26-02 for surgical evaluation of a right hilar mass (biopsy). It was noted that the miner had pulmonary hypertension and pneumoconiosis with asthma/emphysema.

Death Certificate

The death certificate is dated May 7, 2003 (DX 56). The date of the miner's death is listed as April 26, 2003. The immediate cause of death was non small cell carcinoma of lung due to synchronous metastatic lung and liver disease. The underlying cause that initiated events resulting in death was chronic obstructive lung disease. The certifier of the death certificate was Dr. Muhammed Khokar.

Autopsy

An autopsy, limited to the chest only, was performed at Princeton Community Hospital on April 28, 2003 (CX 24; DX 45). The prosector was Dr. Pia who is Board-Certified in Pathology. The final anatomical diagnoses included bilateral pulmonary congestion, bullous emphysema with chronic bronchitis, simple coal worker's pneumoconiosis, and a history of non-small cell carcinoma of right lung with metastases to brain and liver. On gross examination of the lungs small deposits of black pigment were found. Small black nodules ranging from 0.2 to 0.7 cm were found in the cut surfaces of all lobes of the right lung and in the left upper and lower lobes of the left lung. Microscopic examination of the lung tissue revealed areas of fibrosis with abundant deposits of black pigment consistent with a diagnosis of coal worker's pneumoconiosis.

Post-Mortem Reports

Pathology Reports

The medical report of Dr. Naeye is dated February 10, 2004 (EXLM 22;EXLW 1). Dr. Naeye is Board-Certified in Anatomic and Clinical Pathology (EXLM 23; EXLW 2). Dr. Naeye reviewed medical evidence and personally reviewed the autopsy slides. He concluded that there was very mild simple CWP present (less than 0.1% of lung tissue) and that the lesions were too few and small to have caused any measurable abnormalities in lung function that would have caused any disability or prevented the miner from continuing his work as an electrician in the mines. The same applied to the presence of centrilobular emphysema. He added that the miner had severe chronic bronchitis and bronchiolitis. He noted that the obstruction almost completely reversed after a bronchodilator had been administered. Dr. Naeye stated that the miner's death was due to poorly differentiated carcinoma that arose in the right lung and metastasized to other organs. He stated that coal miner's do not have an increased frequency of carcinoma of the lung when cigarette smoking is taken into consideration. He added that airway obstruction caused by centrilobular emphysema and bronchitis that is severe enough to preclude a miner from working is very rare if it indeed occurs at all in the absence of smoking or complicated CWP.

The medical report of Dr. Tomashefski is dated September 29, 2004 (EXLM 36; EXLW 12). Dr. Tomashefski is Board-Certified in Anatomic and Clinical Pathology (EXLM 35). He reviewed the medical evidence in this matter as well as personally reviewing the autopsy slides. He noted that the miner had very mild simple CWP comprising less than 1% of the parenchyma. In addition, he found that the miner suffered from non-small cell cancer of the lungs, liver and probably the pancreas, extensive lung hemorrhage and acute pneumonia bilaterally, moderately severe mixed panacinar and centriacinar bullous emphysema, and other findings consistent with either asthma or chronic bronchitis. He concluded that the metastatic lung cancer was the underlying cause of death. The immediate cause of death was acute hemorrhagic pneumonia. He noted that emphysema and chronic airways disease were contributory causes of death. He stated that the miner's mild simple CWP was too mild in degree to have caused any respiratory symptoms or respiratory impairment. He also concluded that the CWP was neither a cause nor a contributory factor in the miner's death. He added that coal dust exposure and mild simple CWP are not a cause of lung cancer, chronic reactive airways disease, or emphysema. Dr. Tomashefski stated that he would not expect bronchial mucous gland hyperplasia, if it were due to coal dust, to persist five years after the miner left the mines. He added there was no spatial relationship between the miner's emphysema and the few small lesions of CWP present. It was Dr. Tomashefski's opinion that the miner's lung cancer and bullous emphysema were caused by the miner's heavy and sustained exposure to cigarette smoke. He noted that cigarette smoke may have contributed to chronic airways disease but could not exclude the possibility of bronchial asthma.

The corrective report of Dr. Tomashefski is dated December 8, 2004 (EXLM 29; EXLW 14). Dr. Tomashefski advised that he had mistakenly included 2 slides of lymph node and lung tissue from a different individual in his review of the autopsy slides of the miner. The removal of these two slides form his data base did not alter any of his interpretations or conclusions in his 9-29-04 report.

The corrective report of Dr. Naeye is dated December 10, 2004 (EXLM 30; EXLW 15). Dr. Naeye made corrections to his description of the autopsy slides to account for the fact that

two of the slides in his original report were from a different patient. None of his conclusions from his original report were affected by this change.

The medical report of Dr. Perper, who is Board-Certified in Anatomic and Clinical Pathology, is dated December 9, 2004 (CX 25). In a 66-page report Dr. Perper summarized the medical evidence in this matter and offered his comments regarding the medical report of Dr. Naeye. He also provided his own interpretation of the autopsy slides. Dr. Perper concluded that the miner had evidence of pulmonary squamous cell carcinoma of the lung on the background of coal worker's pneumoconiosis, causally associated with both the pulmonary cancer and severe centrilobular emphysema. He added that the pneumoconiosis was a result of the miner's 36 years of coal mine employment. He stated that the severe simple CWP (involving 40 to 50% of the lung parenchyma) and the causally associated centrilobular emphysema, and pulmonary cancer, were in tandem effective combined causes of death that resulted in pulmonary insufficiency and hypoxemia, and terminal bronchopneumonia.

The supplemental report of Dr. Naeye is dated December 28, 2004 (EXLM 38; EXLW 21). In this report, Dr. Naeye discussed the differences between his findings and those of Drs. Perper and Koenig. He noted that it was very difficult to accurately quantitate the overall number and size of anthracotic macules in the lungs of former miners. He added there was no reasonable basis for a claim that CWP had a role in shortening the miner's life. He stated that the tiny crystals of toxic silica were too few in number to have caused tissue destruction and disabling fibrosis. He added that the disabling and finally fatal lung disorders were the result of the miner's cigarette smoking.

The supplemental report of Dr. Tomashefski is dated January 19, 2005 (EXLM 46; EXLW 25). He reviewed the medical reports of Drs. Perper and Koenig. He disagreed with Dr. Perper's assessment of the degree of simple CWP present indicating that he found only 1% of the lung tissue comprised of CWP lesions. He noted that the minimal nature of the CWP was reflected in the radiographic data. He also disagreed with Dr. Perper indicating that the majority of studies do not indicate that coal dust exposure is a cause of lung cancer. He added that the miner's heavy, sustained exposure to tobacco smoke was the most important cause of the moderately severe emphysema. He noted that disabling emphysema due to coal dust is nearly always associated with progressive massive fibrosis which was not present in this case. Dr. Tomashefski stated that the miner's chronic bronchitis was due to smoking and not the result of coal dust exposure. He would expect chronic bronchitis, due to coal dust exposure, to have resolved five years after cessation of dust exposure. He concluded that metastatic lung cancer from cigarette smoking with associated pulmonary hemorrhage and bronchopneumonia was the major cause of death. He stated that the miner's minimal CWP was not a cause or contributory factor in impairment or death. He added that the bullous centracinar emphysema was a contributory factor in the miner's death but that it was not caused by either CWP or coal mine dust. Rather, the miner's emphysema was due to heavy sustained cigarette smoking.

The rehabilitative report of Dr. Perper is dated January 28, 2005 (CX 27). Dr. Perper reviewed four biopsy slides from 1992 and the reports of Drs. Bush, Naeye, Castle, Rosenberg, Spagnolo, and Caffrey. In a 34 page report, Dr. Perper carefully addressed the discrepancies between these reports and his own findings. He concluded that the Employer's consultants

unreasonably downgraded the severity of the miner's CWP and the causal connection between the development of pulmonary emphysema and pulmonary cancer, and the progressive nature of the pneumoconiotic process and pulmonary emphysema, in coal miners as related to past exposure to mixed coal dust. His opinions were unaffected by these additional reports. He added that occupational exposure to mixed coal mine dust for 36 years resulted in significant CWP and causally associated pulmonary emphysema and lung cancer, and constituted a cause of pulmonary disability during life and a contributing factor in the causation of death of the miner and a hastening factor in his death.

The deposition of Dr. Naeye was taken on January 31, 2005 (EXLM 48; EXLW 27). Dr. Naeye agreed that large amounts of silica are known to be a risk factor for the development for lung cancer. The remainder of his testimony was basically a reiteration of the opinions contained within his medical reports.

The deposition of Dr. Perper was taken on February 28, 2005 (EXLM 50; EXLW 29). He explained in detail the basis for his opinion that coal mine dust is associated with the development of lung cancer especially in patient who are smokers. He also discussed how he determined the severity of the CWP lesions. He noted that it was not possible to distinguish between emphysema caused by cigarette smoking and that caused by coal mine dust exposure. The COPD is the clinical counterpart to emphysema which was caused by both smoking and exposure to coal dust. Even if one discarded any association between the miner's occupational history and his cancer, Dr. Perper concluded that CWP and the associated emphysema could not be reasonably discarded as contributory or hastening factors in the miner's death. Dr. Perper was critical of the estimates by Drs. Naeye and Tomashefski regarding the amount of CWP present in the miner's lungs.

The second supplemental report of Dr. Naeye is dated March 3, 2005 (EXLM 58; DXLW 35). Dr. Naeye reviewed the supplemental/rehabilitative reports of Drs. Koenig and Perper. He noted that the claim by Dr. Perper that emphysema was a major disorder was refuted by the results of the vent studies. He noted that Dr. Perper ignored the fact the vent studies reflect the overall status of lung function whereas autopsy prosectors very commonly remove the most diseased tissues they can find to identify, not quantitate disease processes. He agreed that the lung tissues showed moderate to severe centrilobular emphysema whereas the pulmonary function tests showed that the miner's abnormalities were mainly manifestations of airway obstruction.

The second supplemental report of Dr. Caffrey is dated March 16, 2005 (EXLM 60; EXLW 37). He reviewed the supplemental/rehabilitative reports of Drs. Perper and Koenig. He concluded there was nothing additional that would change his conclusions previously rendered in this matter.

The second supplemental report of Dr. Bush is dated April 1, 2005 (EXLM 61; EXLW 38). He reviewed the supplemental/rehabilitative reports of Drs. Perper and Koenig and histologic slides from a biopsy in 2002. He concluded that Drs. Koenig and Perper failed to convince an objective reviewer that coal mine dust disease had any causal role leading to the death of the miner.

Other Post-Mortem Medical Reports

The third medical report of Dr. Koenig, who is Board-Certified in Internal Medicine, Pulmonary Disease, and Critical Care Medicine, is dated December 12, 2004 (CX 26). He reviewed the medical reports of Drs. Naeye and Castle and concluded that the miner's coal dust exposure was of sufficient intensity and duration to cause respiratory impairment in a susceptible individual. He added that the miner was totally disabled from a pulmonary impairment secondary to a combination of simple CWP, COPD, which included centrilobular and bullous emphysema, chronic bronchitis and chronic bronchiolitis, as well as pulmonary hypertension secondary to these disorders. He noted that cigarette smoking may have contributed to the miner's COPD and consequent impairment. He stated that to claim that coal dust did not cause or at least substantially contribute to the miner's disability would be disregarding medical studies and the opinions of many experts that have concluded that coal dust exposure can cause disabling COPD, independent of smoking status and the presence of complicated CWP. Dr. Koenig concluded that the miner's COPD substantially contributed to and/or hastened his death. He noted that since coal dust exposure was the cause of or at least significantly contributed to the miner's COPD, his work in the mines substantially contributed to and/or hastened death.

The rehabilitative report of Dr. Koenig is dated February 5, 200[5] (CX 28). He reviewed the medical reports of Drs. Naeye, Bush, Rosenberg, Spagnolo, Caffrey, Castle, and Tomashefski. He addressed the differences raised in these reports. Dr. Koenig concluded that none of his previous opinions would change based on this new information.

The third supplemental report of Dr. Rosenberg is dated November 18, 2004 (EXLM 25; EXLW 13). He reviewed additional medical evidence including the report of Dr. Naeye, the death certificate, and autopsy report. Dr. Rosenberg concluded that the miner had a minimal degree of CWP which was only diagnosable after death. From a functional perspective, prior to developing lung cancer, the miner was not disabled from performing his last coal mine employment. He added that any emphysema the miner had was not associated with pathologic CWP. He noted that any bronchitis related to past coal dust exposure would dissipate months after coal mine dust exposure ceased. Dr. Rosenberg concluded that, like his lung cancer, the miner's airflow obstruction was smoking related. He stated that the miner's CWP was not associated with any significant ventilatory impairment, and that he was not disabled during his lifetime (prior to developing lung cancer) from performing his last coal mine employment. Dr. Rosenberg concluded also that the miner's death was related to smoking caused lung cancer and it was not caused, contributed to or hastened by coal dust exposure. Any congestion and pneumonia the miner had were related to the terminal events surrounding his extensive carcinoma.

The fourth supplemental report of Dr. Rosenberg is dated January 6, 2005 (EXLM 41; EXLW 23). He reviewed, summarized, and discussed the medical reports of Drs. Perper, Naeye, and Koenig. He favored Dr. Naeye's assessment of the amount of CWP present because in part of the negative CT scans, lack of restrictive impairment, and normal diffusing capacity. He noted that the miner's mild COPD did not shorten the miner's lifespan or cause death. He noted

that the issue of silica and the risk of cancer were quite controversial and that it remains unsolved at present. Dr. Rosenberg stated that none of his previous conclusions had changed.

The third supplemental report of Dr. Castle is dated January 14, 2005 (EXLM 45; EXLW 24). Dr. Castle reviewed additional medical evidence including the reports of Drs. Perper, Naeye, and Koenig. He agreed that the miner had pathologic evidence of simple CWP. He added that review of the additional evidence did not alter any of his previous opinions. He noted that none of the physiologic studies demonstrated a disabling respiratory impairment. It remained his opinion that the miner died as a result of widespread bronchogenic carcinoma involving lymph nodes, liver, and brain. He added that the miner was not a candidate for surgery, not because of poor pulmonary function, but because of metastatic disease. It was his opinion that the miner would have died as and when he did regardless of whether he had CWP.

The deposition of Dr. Zaldivar was taken on January 25, 2005 (EXLM 47; EXLW 26). He is Board-Certified in Internal Medicine and Pulmonary Disease. He testified that he began treating the miner in 1997 for evaluation of pulmonary hypertension. Vent studies showed a mild reversible obstruction. He prescribed breathing medications to the miner. From 1997 to 2002 the miner's functional capacity had not changed from a mild obstruction. He stated that coal mine dust has never been linked to lung cancer. He attributed the mild obstruction to coal mine dust and smoking. He diagnosed chronic bronchitis due to smoking. He noted that pneumoconiosis played no role in the treatment of the cancer. He speculated that any increasing symptoms/impairments after the diagnosis of cancer would have been due to the spread of the cancer. He found pneumoconiosis to be present by chest x-ray. There was no discussion whether the miner would be able to perform his last coal mine employment.

The deposition of Dr. Rosenberg was taken on January 28, 2005 (EXLM 51; EXLW 30). He acknowledged that just because a CT scan is negative does not mean the person does not have pneumoconiosis. The remainder of his testimony was basically a reiteration of his opinions contained within his medical reports.

The fifth supplemental report of Dr. Rosenberg is dated February 7, 2005 (EXLM 54; EXLW 32). He clarified, regarding predicted values in spirometry, that Dr. Koenig's standardization of the miner's value to the Crapo reference values was not appropriate.

The sixth supplemental report of Dr. Rosenberg is dated February 18, 2005 (EXLM 56; EXLW 33). He reviewed the supplemental/rehabilitative reports of Drs. Perper and Koenig. He concluded that an evidence based review of the literature with respect to coal mine dust exposure, couple with the objective findings, indicate that while the miner had a mild degree of medical CWP noted pathologically, his obstructive lung disease and emphysema were not coal mine dust induced. Overall, his respiratory impairments were mild in degree, and the miner had no functional limitations from a pulmonary perspective preventing him from performing his previous coal mine employment. The miner die from metastatic lung cancer and he would have died irrespective of the functional status of his underlying respiratory system.

The fourth supplemental report of Dr. Castle is dated March 3, 2005 (EXLM 57; EXLW 34). He reviewed the supplemental/rehabilitative reports of Drs. Perper and Koenig and

concluded that all of his previously rendered opinions remained unchanged. He noted that the miner did not demonstrate a disabling abnormality of vent function and that CWP and COPD played no role in the miner's death due to metastatic lung cancer. He added that the miner would have developed the same medical problems, including pneumonia, as a result of the metastatic cancer.

The fifth supplemental report of Dr. Crisalli is dated March 8, 2005 (EXLM 59; EXLW 36). Dr. Crisalli reviewed the supplemental/rehabilitative reports of Drs. Perper and Koenig. He noted that *prior to the diagnosis of lung cancer* the miner had only a mild pulmonary functional impairment and maintained the capacity to perform his last coal mine work. He stated that the miner's sparse degree of pneumoconiosis did not contribute in any significant degree to his respiratory impairment and even if CWP was causing all of the impairment, it was mild. The miner was not disabled in any way from the standpoint of his pulmonary functional status. He noted that the metastatic cancer had nothing to do with coal dust exposure. After reviewing the comments by Drs. Perper and Koenig, Dr. Crisalli stated that none of his conclusions would change.

Evidence Admissible in Only the Living Miner's Claim

Occupational Pneumoconiosis Board

On 8-15-85 the Board awarded the miner a 15% pulmonary function impairment attributable to pneumoconiosis (CX 9).

Medical Reports

The medical report of Dr. Fino, who is Board-Certified in Internal Medicine and Pulmonary Disease, is dated June 12, 2001 (EXLM 1). Dr. Fino reviewed and summarized the medical records and concluded there was insufficient evidence to justify a diagnosis of CWP and his opinion the miner did not suffer from an occupationally acquired pulmonary condition. He acknowledged the presence of a mild respiratory impairment from bullous emphysema secondary to cigarette smoking. He found no evidence of a pulmonary disability secondary to the inhalation of coal mine dust.

The medical report of Dr. Castle, who is Board-Certified in Internal Medicine and Pulmonary Disease, is dated November 21, 2001 (EXLM 3). Dr. Castle reviewed and summarized the medical evidence and concluded the miner did not have pneumoconiosis. He noted that the miner's coal dust exposure was sufficient to have caused him to develop CWP in a susceptible host. He noted two other risk factors for the development of pulmonary symptoms: tobacco abuse and pulmonary hypertension. Dr. Castle concluded based on negative physical findings, negative x-rays and CT scans, mild airway obstruction that improved dramatically with bronchodilators consistent with tobacco smoke induced airway obstruction with an asthmatic component, mild hypoxemia due to tobacco smoke induced airway obstruction, that the miner did not suffer from CWP. He added that the miner retained the capacity to perform his last coal mine employment and had at worst a very mild degree of airway obstruction due to his tobacco

smoking habit with significant asthmatic component. His opinion would not change even if the miner were found to have radiographic evidence of CWP.

The supplemental report of Dr. Crisalli is dated February 11, 2002 (EXLM 5). He reviewed additional medical evidence and stated that his conclusions from his last report have not changed.

The supplemental report of Dr. Fino is dated July 10, 2002 (EXLM 9). Dr. Fino reviewed and summarized additional information and stated that the rapid change in lung function form 7-17-00 and 1-17-01 is consistent with the miner's smoking history and not consistent with coal mine dust related pulmonary condition. He concluded that even if the miner had CWP, he had no more than a mild obstructive vent impairment that would not prevent him from returning to his last mining job.

The supplemental report of Dr. Rosenberg is dated July 12, 2002 (EXLM 10). Dr. Rosenberg reviewed and summarized additional medical evidence, including chest x-ray interpretations, CT scans but no new pulmonary function studies, and stated that the additional information did not support a diagnosis of CWP or any respiratory impairment as a consequence of past inhalation of coal mine dust. Basically the remainder of his conclusions was a reiteration of his findings contained within his report of August 14, 2001.

The second supplemental report of Dr. Rosenberg is dated August 13, 2002 (EXLM 17). Dr. Rosenberg reviewed Charleston Area Medical Center Records, the records of Dr. Zaldivar, and the report of Dr. Koenig. Dr. Rosenberg cited to various studies that discussed coal mine dust and the development of COPD. Dr. Rosenberg concluded that COPD could occur in relationship to coal dust exposure but that in this case the miner's long smoking history caused the COPD to develop. He added that coal dust exposure had not appreciably contributed or hastened the development of the obstructive lung disease. While smoking had caused an intermittent flow obstruction, the miner was not permanently and totally disabled consequent to it. The miner was not disabled to the extent he would be unable to perform his previous coal mine job.

The second supplemental report of Dr. Fino is dated August 19, 2002 (EXLM 13). Dr. Fino reviewed additional medical evidence including CT scans and medical reports of Dr. Zaldivar. Dr. Fino noted that the most recent PFT was on 4-30-02 and revealed normal FVC and FEV-1 values. He stated that even assuming the miner had CWP, he did not have sufficient pulmonary impairment to render him disabled. He added that even if all of the miner's obstructive disease was due to coal mine dust inhalation, the miner still would retain the functional capacity to perform his last coal mine employment.

The supplemental report of Dr. Castle is dated August 27, 2002 (EXLM 14). Dr. Castle reviewed additional medical evidence including medical reports from Dr. Zaldivar, CT Scans, the medical report of Dr. Koenig, and a pulmonary function study from 4-30-02. He concluded that the miner did not have CWP and that he did not have the physical findings, the radiographic findings, the physiologic findings, or the arterial blood gas findings indicating the presence of that disease process. He stated that the miner was not totally disabled as a result of a coal mine

dust induced lung disease. He acknowledged that the miner had a mild-moderate degree of airway obstruction due to tobacco smoke induced COPD with a significant asthmatic component. Nevertheless, he added that this abnormality had not caused the miner to have pulmonary disability. Dr. Castle stated that the miner may be disabled due to age and deconditioning. He noted that his opinion was not contingent on having a normal chest x-ray but on having the physiologic abnormalities including disability due to that process.

The second supplemental report of Dr. Crisalli is dated February 21, 2003 (EXLM 17). Dr. Crisalli reviewed additional medical evidence including chest x-ray interpretations, CT scans, and office notes of Dr. McMillen. He concluded that there was nothing in the new evidence that would change his opinions expressed in his reports of February 12, 2001 and February 11, 2002.

The second medical report of Dr. Koenig is dated August 26, 2003 (CX 20). He reviewed treatment records from Drs. McMillen, Khokar, Zaldivar, Gabe, Ghalili, and reports from Drs. Rosenberg, Crisalli, and autopsy findings. He concluded that the miner's coal dust exposure was of sufficient intensity and duration to cause respiratory impairment in a susceptible individual. He added that the miner was totally disabled from a pulmonary impairment secondary to a combination of simple CWP, COPD, which included bullous emphysema and chronic bronchitis, as well as pulmonary hypertension secondary to these disorders. He noted that cigarette smoking may have contributed to the miner's COPD and consequent impairment. He stated that to claim that coal dust did not cause or at least substantially contribute to the miner's disability would be disregarding the autopsy results and the medical studies and the opinions of many experts that have concluded that coal dust exposure can cause disabling COPD, independent of smoking status.

The medical report of Dr. Bush is dated March 1, 2004 (EXLM 26). Dr. Bush is Board-Certified in Anatomic and Clinical Pathology (EXLM 35). He reviewed medical evidence including the medical report of Dr. Koenig and personally reviewed 27 autopsy slides. Dr. Bush concluded the miner had a very mild degree of simple CWP based on the autopsy slides. He added that the lung slides showed a moderate degree of centrilobular emphysema with some bullae. There was also evidence of significant chronic bronchitis typically associated with cigarette smoking. He concluded that the chronic dust disease of the lungs was too limited in degree and extent to have caused disability during lifetime. He noted that said disease affected no more than one percent of the lung tissue. Dr. Bush was also critical of the opinion of Dr. Koenig adding that his opinion did not approach reasonable medical certainty.

The second supplemental report of Dr. Castle is dated November 11, 2004 (EXLM 24). Dr. Castle reviewed additional medical evidence including the death certificate, autopsy report, reports of Drs. Koenig and Naeye. Dr. Castle admitted that the miner had pathologic evidence of minimal simple pneumoconiosis. He noted the miner's mild to moderate degree of airway obstruction (as shown on the 1998 vent studies) with a marked degree of reversibility was consistent with tobacco smoke induced asthmatic bronchitis. He stated the miner did not demonstrate a disabling abnormality of respiratory function prior to the development of lung cancer. He added that the miner was totally disabled prior to death as a result of widespread, metastatic non small cell carcinoma of the lung that was unrelated to coal mine dust exposure.

The medical report of Dr. Spagnolo is dated November 22, 2004 (EXLM 27). Dr. Spagnolo is Board-Certified in Internal Medicine and Pulmonary Disease (EXLM 35; EXLM 44). He reviewed and summarized the medical evidence and concluded there "may" be sufficient pathologic evidence to indicate the presence of a very mild and limited pneumoconiosis. Based on the clinical examinations, lung function ad arterial blood gases, radiographic reports, and lung pathology analysis and review by Dr. Naeye, Dr. Spagnolo concluded that the miner did not have a respiratory or pulmonary impairment contributed to or aggravated by the inhalation of coal mine dust. The miner's lung function when he left the mines in 1997 showed very mild airflow obstruction with significant reversibility with bronchodilator. Dr. Spagnolo was critical of the opinion of Dr. Koenig stating he would place little weight on Dr. Koenig's conclusion of total disability from either pulmonary hypertension or from a reduced FEV-1 value. He admitted that following the diagnosis of cancer the miner suffered from multiple side effects from cancer therapy and during this period the miner clearly had reduced capacity to perform his usual coal mine employment. He added that none of the miner's symptoms, complaints, or medical conditions prior to his death was related to his coal mine employment.

The medical report of Dr. Caffrey is dated November 29, 2004 (EXLM 28). Dr. Caffrey is Board-Certified in Anatomic and Clinical Pathology (EXLM 35; EXLM 44). Dr. Caffrey noted in the cover letter that one of the autopsy slides had been mislabeled with someone else's name. He reviewed medical evidence and personally reviewed the autopsy slides. He concluded that the miner had simple CWP (less than 5% of lung tissue) based on the autopsy slides. He added that the small amount of CWP would not have caused the miner respiratory impairment or disability. The autopsy slides also showed that the miner had chronic bronchitis and centrilobular emphysema. He noted that coal dust could cause both of these diseases but added that because of the small amount of CWP lesions, this amount would not have caused the disability the miner had. Instead the chronic bronchitis and emphysema and lung cancer were due to the miner's heavy smoking.

The third supplemental report of Dr. Crisalli is dated December 10, 2004 (EXLM 37). Dr. Crisalli reviewed additional medical evidence including additional office notes from Dr. Zaldivar, chest x-ray interpretations, biopsy reports, CT scans, death certificate, autopsy report, and report of Dr. Koenig. He agreed that the miner had pathologic evidence of simple CWP but that it was not causing any significant degree of respiratory impairment based on the fact the most recent vent studies and arterial blood gases showed no more than a mild impairment. He concluded the miner retained the pulmonary functional capacity to perform his last coal mine work.

The corrective report of Dr. Bush is dated December 16, 2004 (EXLM 31). He noted that two of the autopsy slides that he reviewed did not belong to the miner. He added however that none of his opinions in his 3-1-04 report have changed due to the error.

The supplemental report of Dr. Bush is dated December 31, 2004 (EXLM 39). Dr. Bush reviewed additional medical evidence including the reports of Drs. Koenig and Perper. He concluded that the conclusions expressed in his report of 3-1-04 remain unchanged.

The supplemental report of Dr. Spagnolo is dated January 9, 2005 (EXLM 42). Dr. Spagnolo reviewed additional medical evidence including the reports of Drs. Bush, Tomashefski, Castle, Rosenberg, Caffrey, Perper, Naeye, and Crisalli. He stated that there is sufficient evidence for the presence of mild CWP in the miner. However, it remained his opinion that the presence of mild CWP did not result in any impairment of lung function or contribute in any way to the miner's death.

The supplemental/corrective report of Dr. Caffrey is dated January 10, 2005 (EXLM 43). He reviewed the medical reports of Drs. Perper and Koenig and the autopsy slides. He noted that in his original report he reviewed two slides that were not from the miner and that was asked to re-evaluate the slides. He concluded that after a review of the slides there was no change in his opinion from what he initially reported. In reviewing the report of Dr. Koenig, Dr. Caffrey stated "Apparently Mr. Tolliver was certainly totally disabled, but no one can ascertain how much disability was due to one cause, namely CWP, versus COPD which in my opinion was mainly due to cigarette smoking." Dr. Caffrey estimated that 5% of the lung parenchyma was affected by CWP and not by itself to have caused any significant pulmonary disability or COPD.

The fourth supplemental report of Dr. Crisalli is dated January 19, 2005 (EXLM 53). He reviewed the medical reports of Drs. Bush, Tomashefski, Rosenberg, Spagnolo, Caffrey, Perper, Naeye, and Koenig. Dr. Crisalli repeated the same conclusions reached in earlier reports and completely discounted the report of Dr. Perper. He also noted that the miner was not disabled in anyway from the standpoint of his pulmonary functional status.

The deposition of Dr. Castle was taken on February 14, 2005 (EXLM 49). Dr. Castle stated that before the onset of lung cancer the miner had the pulmonary capacity to return to his coal mine employment as an electrician doing some heavy labor. He attributed the obstruction to smoking or an asthmatic component. He noted that CWP does not cause a reversible obstruction. He noted there was no relationship between coal mine dust and lung cancer. He acknowledged silica is a known carcinogen but that no one diagnosed silicosis in this case. The remainder of his testimony was basically a reiteration of his opinions contained within his medical reports.

The deposition of Dr. Tomashefski was taken on February 16, 2005 (EXLM 52). He noted that terminally the miner suffered from breathlessness caused by pneumonia and underlying emphysema, chronic bronchitis, and asthma. He admitted he had no information regarding the exertional requirements of the miner's position as an electrician. The remainder of his testimony was basically a reiteration of his opinions contained within his medical reports.

The second supplemental report of Dr. Spagnolo is dated February 19, 2005 (EXLM 55). He reviewed the medical reports of Drs. Perper and Koenig and stated that his opinion on this matter had not changed.

Miscellaneous Medical Records

The record contains the medical records from Charleston Area Medical Center (EXLM 18). These records pertain to evaluation of a right lung mass in 2002.

The record contains the medical notes of Dr. Gabe (CX 21). Dr. Gabe, a radiation oncologist, treated the miner for his lung cancer from September of 2002 to March of 2003.

The record contains a medical note from Dr. Craft dated June 8, 1998 (CX 13). After reviewing the result of a normal pulmonary function study, Dr. Craft noted that this study did not correlate at all with the miner's chest x-ray finding of moderate obstructive pulmonary disease.

I. Miner's Claim[8]

In order to receive benefits under the Act, a claimant must prove all of the following four elements of entitlement: (1) the miner had pneumoconiosis, (2) the pneumoconiosis arose out of coal mine employment, (3) was totally disabled from a respiratory or pulmonary standpoint, and (4) that the pneumoconiosis contributed to his total disability.

In this case, the parties stipulated to the presence of clinical pneumoconiosis and to the presence of an obstructive lung disease (TR 6, see Employer's closing brief). It was also agreed that the miner had adequate coal mining and smoking history to put him at risk for both diseases (TR 6-7).

Although the parties stipulated to the presence of clinical pneumoconiosis, the presence of legal pneumoconiosis is still at issue.

All of the physicians agreed that the miner suffered from some form of chronic obstructive lung disease (including emphysema and chronic bronchitis) but disagreed as to the cause. Drs. Perper and Koenig concluded that the COPD was due, at least in part, to coal mine dust exposure and the results of the miner's prolonged smoking history. Conversely, Drs. Crisalli, Rosenberg, Naeye, Tomashefski, Caffrey, Bush, Castle, Fino, and Spagnolo discount for various reasons the connection between COPD (including emphysema and chronic bronchitis) and the miner' coal mine dust exposure (i.e. no legal pneumoconiosis).

I find that the well-reasoned, well-documented opinions of Drs. Perper and Koenig to be more persuasive on this issue. Their reports are consistent with the miner's subjective complaints, medical history, objective diagnostic testing, history of coal mine employment, smoking history, and autopsy findings. Moreover, Drs. Perper and Koenig clearly articulated the basis for their opinions and cited to medical studies in support of their conclusions. I specifically find that the opinions offered and/or the medical studies relied on by Drs. Naeye, Rosenberg, Tomashefski, Fino, and Bush are hostile- to- the- Act and are less credible and should be accorded less weight. Overall, when compared with the reports of Drs. Perper and Koenig, I find

[8] It has been consistently reported throughout the medical records that the miner had a smoking history of at least one pack per day for 40 plus years. In evaluating the evidence, I will consider the miner to have had a heavy and prolonged history of tobacco smoke abuse.

unpersuasive the attempts by Drs. Crisalli, Rosenberg, Naeye, Tomashefski, Caffrey, Bush, Castle, Fino, and Spagnolo to exclude or minimize the effects of coal mine dust exposure on the miner's health while attributing all of the miner's pulmonary problems to cigarette smoking. Accordingly, I find that Claimant has established the presence of legal pneumoconiosis pursuant to §718.201(a)(2).

Since the miner was employed in the coal mine for more than 30 years, he qualifies for the rebuttable presumption that the pneumoconiosis arose out of his coal mine employment. §718.203(b). I find that Employer has not set forth sufficient evidence to rebut said presumption. Therefore, Claimant has established that the miner's pneumoconiosis arose out of his coal mine employment.

Therefore, the remaining issues are whether the miner had a totally disabling respiratory or pulmonary impairment and whether pneumoconiosis contributed to said impairment.

Claimant must prove that the miner was totally disabled due to pneumoconiosis. §§718.204(b)(1),(c)(1). This is a two pronged element.

First, Claimant must prove that the miner suffered from a totally disabling respiratory or pulmonary impairment. A miner shall be considered totally disabled if the miner has a pulmonary or respiratory impairment which, standing alone, prevents or prevented the miner from performing his usual coal mine work or comparable employment. §718.204(b)(1). Section 718.204 sets out the standards for determining total disability. This section provides that in the absence of contrary probative evidence, evidence that meets the quality standards of the subsection shall establish the miner's total disability.

Subsection 718.204(b)(2)(i) provides that total disability may be established by pulmonary function testing. There are six pulmonary function studies submitted as part of the miner's claim for benefits. As none of the studies were qualifying under the Act, I find that Claimant has failed to establish total disability due to §718.204(b)(2)(i).

Subsection 718.204(b)(2)(ii) provides that qualifying arterial blood gas testing may establish total disability. There are three arterial blood gas studies in the record. The most recent study, from 2001, was qualifying. This study was validated by Dr. Gaziano. Because it is the most recent evidence of the miner's condition, I find the study from 2001 to be more probative. Accordingly, I find that Claimant has established total disability pursuant to §718.204(b)(2)(ii).

There is no evidence that the miner suffered from cor pulmonale with right-sided congestive heart failure pursuant to §718.204(b)(2)(iii).

Subsection 718.204(b)(2)(iv) provides that total disability may be established if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concluded that the miner's respiratory or pulmonary impairment prevented him from engaging in his usual coal mine work or in comparable and gainful employment.

There are fourteen (14) physicians who have rendered an opinion in this matter relative to this issue. Drs. Gaziano, Koenig, and Perper found the miner had a totally disabling pulmonary impairment. Dr. Caffrey admitted in his 1-10-05 report that the miner was totally disabled. Drs. Tomashefski, Bush, and Fino concluded the miner had no pulmonary impairment. Drs. Crisalli (report of 3/8/05), Rosenberg (report of 11-18-04), Castle (report of 11-11-04), and Spagnolo (report of 11-22-04) indicated that *prior to the miner's development of lung cancer* the miner was not totally disabled. Dr. Naeye stated in his supplemental report of 12-28-04 that "his disabling and finally fatal lung disorders were the result of his [the miner's] cigarette smoking" suggesting that the miner did have a totally disabling lung condition prior to death. At his deposition, Dr. Zaldivar mentions that the miner could do heavy work. While noting the miner had significant dyspnea due to emphysema, pneumoconiosis, and pulmonary hypertension, Dr. McMillen offered no opinion as to whether the miner had a disabling pulmonary impairment, accordingly his opinion will be accorded less weight.

I accord great weight to the opinions of Drs. Koenig, and Perper on this issue. [9] Their opinions are well-reasoned and are consistent with the medical records documenting the miner's declining health due to metastatic lung cancer particularly between 2002 and 2003, the qualifying arterial blood gases from 2001, miner's complaints of "significant dyspnea" (as documented by Dr. McMillen), and the physical requirements of the miner's last position as an electrician that required him to perform heavy duty tasks, at least intermittently throughout the work day, including lifting 75 to 80 pounds and carrying a tool belt that weighed 80 pounds. Dr. Koenig, in particular, analyzed the miner's condition and carefully evaluated his ability to perform his last coal mine duties.[10]

Although the pulmonary function studies showed only a mild, reversible airway obstruction, the last vent study in the record was conducted in April of 2002, a whole year prior to the miner's death. It is arguable that up to April of 2002, the miner was not totally disabled based on the results of the vent studies. However, from April of 2002 to April of 2003, one can reasonably infer from the voluminous medical records in this matter that the miner's pulmonary condition dramatically declined due to his widespread metastatic lung cancer. Logic would dictate that most certainly at some point before his death (from lung cancer) the miner had to have a totally disabling pulmonary impairment that would have prevented him from performing his last coal mine employment. The reasoned medical opinions of Drs. Koenig and Perper support this conclusion.

The regulations provide that in order to receive benefits a miner must establish that *at some point in his life* he developed a totally disabling respiratory impairment. I find that the reports of Drs. Crisalli, Rosenberg, Castle, and Spagnolo are fundamentally flawed to the extent that they chose to base their opinions of total disability on data (specifically pulmonary function studies) collected before the miner was diagnosed with lung cancer. It is not consistent with the

[9] I accord less weight to the opinion of Dr. Gaziano on this issue. He authored one report in 2000 and did not have the benefit of reviewing the additional medical evidence in this matter. Moreover, I find that he did not provide an adequate rationale for his findings.

[10] I accord less weight to the equivocal opinion of Dr. Caffrey who stated that "apparently Mr. Tolliver was certainly totally disabled." Moreover, Dr. Caffrey did not provide an adequate rationale for said conclusion.

regulations for a medical consultant to arbitrarily choose some point in the miner's life on which to base their opinions of total disability. In fact, Drs. Crisalli, Rosenberg, Castle, and Spagnolo all state or imply, in at least one of their medical reports, that their ultimate conclusion of no total respiratory disability was based on the miner's condition before he was diagnosed with lung cancer.[11] In addition, Drs. Tomashefski and Bush opined the miner's CWP was too mild to have caused respiratory disability but they failed to address the larger question of whether the miner actually had a totally disabling respiratory condition sometime prior to his death.[12] I find that the opinions of Drs. Tomashefski, Bush, Fino, Crisalli, Rosenberg, Castle, and Spagnolo are, at best, equivocal as to the presence of a totally disabling respiratory impairment and are not credible and should be accorded little weight on this issue.

In addition, I find the medical report of Dr. Fino is not well-reasoned and should be accorded little weight. For one, his three reports were authored in 2001 and 2002 and did not take into account the medical evidence developed after the miner was diagnosed with lung cancer. Dr. Fino did not have the opportunity to review the additional medical evidence developed after August of 2002. Perhaps if Dr. Fino knew the miner died from metastatic lung cancer his opinion regarding the presence of a totally disabling pulmonary impairment would be different. In addition, Dr. Fino's conclusions were not well-reasoned and there was no detailed discussion of the miner's job or the exertional requirement of his job in comparison with the miner's acknowledged obstructive impairment. For these reasons, I accord the opinion of Dr. Fino less weight.

In addition to reasons previously listed, I accord the opinion of Dr. Tomashefski less weight. At his deposition he openly admitted that he did not know the miner's last job and did not know the exertional requirements of said position. Accordingly, any assessment of total disability by Dr. Tomashefski is accorded less weight.

Dr. Zaldivar, the miner's treating physician, stated at his deposition that the miner had a mild obstructive impairment and could perform heavy labor. However, this statement is not a well-reasoned, well-documented opinion regarding the exertional requirements and the physical ability of the miner to perform said work. Moreover, Dr. Zaldivar's opinion was in regard to the results of a pulmonary function study and did not take into account the fact that the miner later developed metastatic lung cancer. He did not give an opinion whether the miner was totally disabled before his death. For these reasons, I accord the opinion of Dr. Zaldivar less weight.

Claimant has proved, by the preponderance of the physician opinion evidence, total disability at §718.204(b)(2)(iv).

I must weigh together the different types of evidence at §§718.204(b)(2)(i)-(iv), *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195 (1986). I note that these methods are alternative, not

[11] Employer may argue that there were no pulmonary function studies after 2002 and that there was no objective basis for the doctors to find total disability beyond that time. However, all of the Employer's consultants had access to all of the medical evidence in this matter. In fact most of them authored at least 4 reports each in this case. I find that there is ample medical evidence in the record to conclude that the miner had a totally disabling pulmonary impairment before his death.

[12] I accord less weight to the opinion of Dr. Naeye who alluded to the fact that the miner had a totally disabling respiratory impairment but provided no explanation for his conclusion.

requisite, means to prove total disability. The fact that the miner did not meet each of the criteria does not preclude a finding of total disability. I find the physician opinion evidence the most probative means to prove total disability as it is not based on isolated numeric criteria or a specific finding. Physician opinion evidence takes into consideration a totality of factors. The physician opinion evidence, especially the findings of Drs. Perper and Koenig, support a finding of total disability. I find that Claimant has proved, by the preponderance of the overall evidence, the existence of a totally disabling respiratory or pulmonary impairment. §718.204(b)(1).

Finally, Claimant must prove that pneumoconiosis was a substantially contributing cause of the miner's disabling respiratory or pulmonary impairment. §718.204(c)(1).

Pneumoconiosis is a substantially contributing cause of a miner's disability if it has a material adverse effect on the miner's respiratory or pulmonary condition. §718.204(c)(1)(i). The Department of Labor noted in its comments that the addition of the word "material" to the regulation reflects the view that "evidence that pneumoconiosis makes only a negligible, inconsequential, or insignificant contribution to the miner's total disability is insufficient to establish that pneumoconiosis is a substantially contributing cause of that disability." Regulations Implementing the Federal Cal Mine Health and Safety Act of 1969, 65 Fed. Reg. 79,946 (December 20, 2000).

All of the physicians agreed that the miner suffered from clinical pneumoconiosis. However, there is a vast discrepancy among the pathologists as to the amount of pneumoconiosis present in the miner's lungs. Dr. Perper estimated that pneumoconiosis consumed about 40-50% of the lung tissue whereas Drs. Naeye, Tomashefski, Caffrey and Bush assert that the pneumoconiosis was minimal only consuming 1 to 5% of the lung tissue. I find that the opinion of Dr. Perper is consistent with the prosector's observations of lesions of up 0.7 cm in all lobes of the right lung and lesions of pneumoconiosis up to 0.4 cm in the left lung. On the other hand the opinions of Drs. Naeye, Tomashefski, Caffrey, and Bush seem more in line with the mostly negative chest x-rays and CT Scans.

Keeping this mind, I accord greater weight to the opinions of Drs. Perper and Koenig on this causation issue. Dr. Perper found that the miner's clinical CWP (that occupied 40-50% of the lung tissue on autopsy) was a cause of his emphysema and chronic bronchitis and thus a significant factor in his totally disabling respiratory disability. His opinion is well-reasoned and well-documented and is consistent with the autopsy prosector's findings and my earlier finding of total respiratory disability. Moreover, in adopting Dr. Naeye's interpretation of the autopsy slides, Dr. Koenig found that the miner's clinical CWP was too mild to cause impairment but concluded the miner's COPD, due at least in part to coal mine dust exposure, contributed to the miner's totally disabling respiratory impairment. Again, I find Dr. Koenig's opinion to be well-reasoned and consistent with the medical evidence in this case and the scientific literature contained within the regulations.

Drs. Naeye, Tomashefski, Bush, and Caffrey stated that the miner's clinical CWP was too mild, in and of itself, to have caused any respiratory impairment. This may be so in an otherwise healthy individual. However, I find that these physicians failed to explain or discuss the effects of a 1-5% loss of lung function due to CWP in a patient with metastatic lung cancer.

This 1-5% loss of function may be critical in a patient in these circumstances. Moreover, the clinical CWP does not have to be the sole cause of the disability but merely a significant contributing factor to the total disability. For these reasons, I accord the opinion of Drs. Naeye, Bush, Tomashefski, and Caffrey less weight.

In addition, I find that since Drs. Crisalli, Rosenberg, Naeye, Tomashefski, Caffrey, Bush, Castle, Fino, and Spagnolo do not adequately: (1) consider the effects of the miner's clinical pneumoconiosis (assuming it encompasses 1-5% of lung tissue) in combination with his other pulmonary problems (lung cancer, pneumonia, emphysema, chronic bronchitis, and possible asthma), (2) recognize the established presence of legal pneumoconiosis, (3) conclude that the miner had a total disabling respiratory impairment, I find that their opinions regarding disability causation are entitled to less weight. *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109 (4th Cir. 1995).

Relying on the opinions of Drs. Perper and Koenig I find Claimant has proved, by the preponderance of the evidence, that pneumoconiosis was a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment. §718.204(c)(1).

Claimant has proved each of the requisite elements of entitlement on the miner's claim.

I award benefits on the miner's claim.

II. Survivor's Claim

To receive survivor's benefits under the Black Lung Benefits Act, Claimant must prove, by the preponderance of the evidence, that : (1) the miner had pneumoconiosis; (2) the miner's pneumoconiosis arose out of coal mine employment; and (3) that miner's death was due to the disease.

Claimant has already proved that the miner had pneumoconiosis and that it arose out of coal mine employment. §§718.202(a); 718.203(b).

Death will be considered to be due to pneumoconiosis if the preponderance of the evidence proves that pneumoconiosis caused, contributed to, or hastened the miner's death. §718.205(c).

Only Dr. Perper attributed the miner's death directly to pneumoconiosis. He asserted that the miner's lung cancer was due to coal mine dust exposure. All of the other medical consultants in this matter disagreed with Dr. Perper's opinion concluding the lung cancer was most likely due to cigarette smoking. I find that this topic is controversial and that the medical literature on this topic is, at best, divided. There does not, at this time, seem to be a definitive study that links coal mine dust to the development of lung cancer. For this reason, I accord the opinion of Dr. Perper less weight on this specific issue.

There are six physicians who have rendered opinions relevant to the contributing cause of death issue. Drs. Perper and Koenig concluded that the miner's pneumoconiosis contributed to

the miner's death to lung cancer. Drs. Naeye, Tomashefski, Rosenberg, and Castle concluded pneumoconiosis did not contribute to or hasten the miner's death. The autopsy prosector listed pneumoconiosis as a final diagnosis but did not comment on whether it contributed to the miner's death. The death certificate, certified by Dr. Khokar, listed metastatic lung cancer as the cause of death with an underlying cause noted as COPD. Dr. Khokar did not state a cause of the COPD, therefore his opinion will be accorded less weight.

I note there is a large disparity between the reports of Dr. Perper and those of Drs. Naeye and Tomashefski regarding the amount of pneumoconiosis present in the miner. As stated earlier, I find that the assessment of 40-50% by Dr. Perper appears consistent with the autopsy findings. In addition, the assessments of 1-5% by Drs. Naeye and Tomashefski appear consistent with the largely negative chest x-rays and CT scans. All three offer reasoned explanations for their findings.

Nevertheless, I find more credible the well-reasoned opinions of Drs. Perper and Koenig. Dr. Perper stated at his deposition that even if coal mined dust was found not to have caused the miner's lung cancer, it was still his opinion that clinical pneumoconiosis and the associated emphysema could not be discarded as contributory factors in the miner's death. He clearly set forth in detail the reasoning for his findings noting the miner had pneumoconiosis, COPD due to coal mine dust and smoking, and lung cancer. These conditions were combined causes of death that resulted in pulmonary insufficiency, hypoxemia, and terminal bronchopneumonia. Dr. Koenig reached similar conclusions in his reports.

Conversely, I accord less weight to the opinions of Drs. Naeye, Tomashefski, Rosenberg, and Castle. They all concluded that the clinical pneumoconiosis was too mild to have contributed to death. Moreover they discounted or minimized the possible connection between the miner's COPD and coal mine dust exposure. Perhaps it is arguable the clinical pneumoconiosis or legal pneumoconiosis, in and of itself, was too minimal to have caused death in a person with otherwise good pulmonary function. However, what I find troubling in these reports is the lack of a frank discussion regarding the effects of pneumoconiosis (clinical and/or legal) in a patient with metastatic lung cancer, bronchopneumonia, emphysema, and chronic bronchitis. Even if one were to accept that the miner had only 1-5% of his lung function destroyed by clinical pneumoconiosis, would this be enough to contribute or hasten a death in a person who has metastatic lung cancer, emphysema, chronic bronchitis, and pneumonia? It is this question that Drs. Naeye, Tomashefski, Rosenberg, and Castle fail to adequately answer. For these reasons, I accord the opinions of Drs. Naeye, Tomashefski, Rosenberg, and Castle less weight.

Relying on the opinion of Dr. Perper, I find that Claimant has proved, by the preponderance of the evidence, the miner's death was due to pneumoconiosis. §718.205(c).

I award benefits on the survivor's claim.

Attorney's Fees

No award of attorney's fees for services to the Claimant is made herein since no application has been received. Thirty days are hereby allowed to Claimant's counsel for the submission of such application. His attention is directed to 20 C.F.R. §§725.365 and 725.366 of the regulations. A service sheet showing that service has been made upon all parties, including the Claimant, must accompany the application. Parties have ten days following receipt of such application within which to file any objections. The Act prohibits the charging of a fee in the absence of an approved application.

ORDER

Maple Meadow Mining Company is ORDERED to pay benefits on the miner's claim beginning June 2000, the month the miner filed his claim for benefits, as augmented by Claimant as a dependent spouse and their adopted son, Justin, and ending March 2003, the month before the miner's death. §§725.203(b), 725.503(b)

Maple Meadow Mining Company is ORDERED to pay benefits on the survivor's claim beginning April 2003, the month of the miner's death, as augmented by her adopted son, Justin. §718.503(c).

A

GERALD M. TIERNEY
Administrative Law Judge

Notice of Appeal Rights: Pursuant to 20 C.F.R. §725.481, any party dissatisfied with this Order may appeal it to the Benefits Review Board within 30 days from the date of this decision, by filing a Notice of Appeals with the Benefits Review Board, P.O. Box 37601, Washington, D.C. 20013-7601. A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits. His address is Room N-2117, Frances Perkins Building, 200 Constitution Avenue, N.W., Washington, D.C. 20210.